

General

Title

Language services: the percent of encounters where the wait time for an interpreter is 15 minutes or less.

Source(s)

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Measure Domain

Primary Measure Domain

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the [Measure Validity](#) page.

Secondary Measure Domain

Access

Brief Abstract

Description

This measure is used to assess the percent of encounters where the wait time for an interpreter is 15 minutes or less.

Rationale

Patients and providers report resistance or reluctance to using interpreter services due to long wait times or delays in obtaining an interpreter upon request. As interpreter services continue to evolve, many hospitals across the country have adopted standards for wait times for interpreter encounters. This measure provides information on the extent to which interpreter services are able to respond to requests for service within a reasonable amount of time, defined here as within 15 minutes.

Primary Clinical Component

Limited English proficiency (LEP); wait time for interpreter

Denominator Description

The total number of interpreter encounters (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

The number of interpreter encounters in which the wait time is 15 minutes or less for the interpreter to arrive (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Evidence Supporting the Criterion of Quality

A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences

Evidence Supporting Need for the Measure

Need for the Measure

Variation in quality for the performance measured

Evidence Supporting Need for the Measure

Institute of Medicine (IOM), Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington (DC): National Academy Press; 2001. 360 p.

Regenstein M, Huang J, West C, Trott J, Stegun M. Hospital language services: quality improvement and performance measures. Advances in patient safety: new directions and alternative approaches. Vol. 1-4. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. (AHRQ publication; no. 08-0034).

U.S. Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care [Final report]. Rockville (MD): U.S. Department of Health and Human Services, Office of Minority Health; 2001 Mar.

State of Use of the Measure

State of Use

Current routine use

Current Use

Collaborative inter-organizational quality improvement

Decision-making by managers about resource allocation

Internal quality improvement

Monitoring and planning

Quality of care research

Application of Measure in its Current Use

Care Setting

Ambulatory Care

Hospitals

Physician Group Practices/Clinics

Professionals Responsible for Health Care

Measure is not provider specific

Lowest Level of Health Care Delivery Addressed

Group Clinical Practices

Target Population Age

All ages

Target Population Gender

Either male or female

Stratification by Vulnerable Populations

Interpreter encounters for non-English speaking populations can be stratified by language so that organizations can identify language resource needs for effective planning.

Characteristics of the Primary Clinical Component

Incidence/Prevalence

- 22.3 million U.S. residents (8.4%) have limited English proficiency (LEP).
- Between 1990 and 2000, the number with LEP grew by 53%.
- 80% of hospitals reported treating LEP patients on a regular basis.

Evidence for Incidence/Prevalence

Flores G. Language barriers to health care in the United States. *N Engl J Med*. 2006 Jul 20;355(3):229-31. [PubMed](#)

Hasnain-Wynia RJ, Yonek R, Pierce D, Kang GC. Hospital language services for patients with limited English proficiency: results from a national survey. *The Commonwealth Fund*; 2006 Oct.

U.S. Bureau of the Census. American Community Survey: language spoken at home (table S1601). 2005.

Association with Vulnerable Populations

- Hispanics who do not speak English at home are less likely to receive all recommended health care services.
- Follow-up compliance, adherence to medications, and patient satisfaction are significantly lower for limited English-proficient (LEP) populations than they are for English speaking patients.
- Language barriers are associated with less health education, worse interpersonal care, and lower patient satisfaction.
- LEP populations are less likely to receive preventative health services such as mammograms.

Evidence for Association with Vulnerable Populations

Andrulis D, Goodman N, Pryor N. What a difference an interpreter can make: health care experiences of uninsured with limited English proficiency. *The Access Project*; 2003 Apr.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. *J Gen Intern Med*. 2007 Nov;22 Suppl 2:283-8. [PubMed](#)

David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt Sinai J Med*. 1998 Oct-Nov;65(5-6):393-7. [PubMed](#)

Ku L, Waidmann T. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2003 Aug. 29 p.

Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B, Kaplan SH. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. *J Gen Intern Med*. 2007 Nov;22 Suppl 2:324-30. [PubMed](#)

Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services. *J Gen Intern Med*. 1997 Aug;12(8):472-7. [PubMed](#)

Burden of Illness

- Long waits delay diagnosis and treatment adding to emotional distress and physical harm may result. Waiting times should be reduced for both patients and those who give care. Delays suggest care is not designed with the welfare of the patient at the center.
- Persons with limited English proficiency (LEP) experience disproportionately high rates of infectious disease and infant mortality.

- Persons with LEP are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease.

See also the "Association with Vulnerable Populations" field.

Evidence for Burden of Illness

Institute of Medicine (IOM), Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington (DC): National Academy Press; 2001. 360 p.

Office of Minority Health and Health Disparities. Eliminating racial and ethnic disparities.

Utilization

See the "Association with Vulnerable Populations" field.

Costs

- Physicians who are unable to communicate effectively with their patients often compensate by engaging in costly practices such as: more diagnostic procedures; more invasive procedures; overprescribing medications.
- Language barrier between physicians and their patients are associated with a \$38 increase in test charges and 20-minute longer emergency department (ED) stay.
- ED decision making behavior (e.g., diagnostic testing, admission, IV hydration) is more costly when non-English speaking patients did not receive care from bilingual physician or with an interpreter present.
- The average cost per interpretation for health maintenance organizations (HMOs) patients was \$79 and the total cost per year was \$279, a relatively small cost given total medical expenditures, and given improved patient utilization of preventive and primary care services that may reduce long-term medical costs.

Evidence for Costs

Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. Pediatrics. 1999 Jun;103(6 Pt 1):1253-6. [PubMed](#)

Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Arch Pediatr Adolesc Med. 2002 Nov;156(11):1108-13. [PubMed](#)

Jacobs EA, Shepard DS, Suaya JA, Stone EL. Overcoming language barriers in health care: costs and benefits of interpreter services. Am J Public Health. 2004 May;94(5):866-9. [PubMed](#)

Ku L, Flores G. Pay now or pay later: providing interpreter services in health care. Health Aff (Millwood). 2005 Mar-Apr;24(2):435-44. [PubMed](#)

Institute of Medicine (IOM) Healthcare Quality Report

Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Data Collection for the Measure

Case Finding

Users of care only

Description of Case Finding

All encounters where limited English-proficient (LEP) patients received interpreter services

Denominator Sampling Frame

Patients associated with provider

Denominator Inclusions/Exclusions

Inclusions

The total number of interpreter encounters, including:

- On-site interpreter encounters with hospital operated interpreters, and on-site contract and/or agency interpreters

- Hospital and outside vendor telephone interpreting

- Hospital and outside vendor video interpreting

- Scheduled and unscheduled interpreter encounters

Note: Stratified by language.

Exclusions

Encounters with bilingual providers and/or other bilingual workers/employees

Relationship of Denominator to Numerator

All cases in the denominator are equally eligible to appear in the numerator

Denominator (Index) Event

Encounter

Denominator Time Window

Time window is a single point in time

Numerator Inclusions/Exclusions

Inclusions

The number of interpreter encounters in which the wait time is 15 minutes or less for the interpreter to arrive, for encounters provided by:

- On-site interpreter encounters with hospital operated interpreters, and on-site contract and/or agency interpreters
- Hospital and outside vendor telephone interpreting
- Hospital and outside vendor video interpreting
- Scheduled and unscheduled interpreter encounters

Note: Stratified by language.

Exclusions

- Encounters where the wait time is greater than 15 minutes for interpreter to arrive
- Encounters with bilingual providers and/or other bilingual hospital workers/employees

Measure Results Under Control of Health Care Professionals, Organizations and/or Policymakers

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

Numerator Time Window

Fixed time period

Data Source

Administrative data

Medical record

Level of Determination of Quality

Individual Case

Pre-existing Instrument Used

Unspecified

Computation of the Measure

Scoring

Rate

Interpretation of Score

Better quality is associated with a higher score

Allowance for Patient Factors

Analysis by high-risk subgroup (stratification on vulnerable populations)

Description of Allowance for Patient Factors

Data reported as aggregate numerator and denominator, monthly, stratified by language.

Standard of Comparison

Internal time comparison

Evaluation of Measure Properties

Extent of Measure Testing

The measure was pilot tested in one inpatient and in one outpatient care setting in two (2) large metropolitan hospitals October 2006.

The measure was used by the 10 grantee hospitals in the Speaking Together National Language Services Collaborative from November 2006 - May 2008. Ten (10) hospitals reported data monthly on 40,000 - 60,000 patients seen in inpatient and ambulatory care settings. Hospitals ranged in size from 11,500 - 44,000 admissions, included 2 children's hospitals and were comprised of both academic teaching and non-teaching community hospitals.

The measures specifications were revised based on the learning from the Speaking Together Collaborative and input from the participating hospitals.

Refer to original measure documentation for additional information.

Evidence for Reliability/Validity Testing

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Identifying Information

Original Title

L3: patient wait time to receive interpreter services.

Measure Collection Name

Language Services Performance Measures

Submitter

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

Developer

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

Funding Source(s)

Robert Wood Johnson Foundation

Composition of the Group that Developed the Measure

Marsha Regenstein, PhD, MCP - Research Professor, Department of Health Policy Co-Director, Center for Health Care Quality, The George Washington University

Jennifer Huang, MS - Research Scientist, Center for Health Care Quality, The George Washington University

Holly Mead, PhD - Assistant Research Professor, Center for Health Care Quality, The George Washington University

Jennifer Trott, MPH - Research Associate, Center for Health Care Quality, The George Washington University

Catherine West, MS, RN - Senior Research Scientist, Center for Health Care Quality, The George Washington University

Wilma Alvarado-Little - Co-Chair, National Council on Interpreting in Health Care Board Program Manager Center for the Elimination of Minority Health Disparities, University at Albany, SUNY Albany, NY

Oscar Arocha, MM - Director of Interpreter Services, Department and Guest Support Services, Boston Medical Center, Boston, MA

Rochelle Ayala, MD - Administrator and Chief Medical Officer for Primary Care Services, Memorial Healthcare System. Hollywood, FL

Sang-ick Chang, MD - Vice President and Medical Director of Ambulatory Services, San Mateo Medical Center, San Mateo, CA

Lou Hampers, MD, MPH - The Children's Hospital Denver. Denver, CO

Anita Hunt - Director Guest Services/Performance Improvements Regional Medical Center at Memphis, Memphis, TN

Matt Wynia, MD, MPH - Director, The Institute for Ethics American Medical Association

Wendy Jameson - Director, California Health Care Safety Net Institute, Oakland, CA

Bret A. McFarlin, DO - Director, Internal Medicine Broadlawns Medical Center, Des Moines, IA

Gloria Garcia Orme, RN, MS - Director, Patient Relations, San Francisco General Hospital, San Francisco, CA

Melinda Paras - CEO, Paras and Associates, Albany, CA

Martine Pierre-Louis, MPH - Director, Community and Patient Access Services, Harborview Medical Center, Seattle, WA

Angelique Ramirez, MD - Medical Director, Community Oriented Primary Care, Parkland Health & Hospital System, Dallas, TX

Cynthia Roat - Quality Assurance Specialist Board Co-Chair, National Council on Interpreting in Health Care

Bruce Siegel, MD, MPH - Director, Center for Health Care Quality, The George Washington University, School of Public Health and Health Services

Richard A. Wright, MD, MPH, FACPE - Management Consultant, Wright Consulting

Bret A. McFarlin, DO - Director, Internal Medicine, Broadlawns Medical Center

Gloria Garcia Orme, RN, MS - Director, Patient Relations, San Francisco General Hospital

Boston Medical Center

Children's Hospital of Philadelphia

Maribet McCarty, PhD, RN - Director, Measurement and Data, Regions Hospital

Sidney Van Dyke, MA - Manager, Interpreter Services, Regions Hospital

Loretta Saint-Louis, PhD - Multilingual Quality Specialist, Cambridge Health Alliance

Sarah Rafton, MSW - Center for Diversity, Children's Hospital & Regional Medical Center

Kathy Miraglia, MS - Manager, Interpreter Services, University of Rochester Medical Center

Sally Moffat, RN - Director, Community Outreach and Language Services, Phoenix Children's Hospital

Dena Brownstein, MD - Associate Medical Director, Patient Safety, Seattle Children's Hospital

Financial Disclosures/Other Potential Conflicts of Interest

No disclosures.

Adaptation

Measure was not adapted from another source.

Release Date

2006 Nov

Revision Date

2009 Aug

Measure Status

This is the current release of the measure.

Source(s)

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Measure Availability

The individual measure, "L3: Patient Wait Time to Receive Interpreter Services," is published in "Aligning Forces for Quality. Language Services Performance Measures Implementation Guide."

For more information, please contact Catherine West, Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services, 2121 K Street, Suite 200, Washington, DC 20037; Telephone: 202-994-8663; Fax: 202-994-3500; E-mail: Cathy.West@gwumc.edu.

NQMC Status

This NQMC summary was completed by ECRI Institute on May 17, 2010. The information was verified by the measure developer on July 2, 2010.

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For additional information regarding the use of these measures, contact Catherine West at Cathy.West@gwumc.edu.

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